

Vendor Approver Certification

ADP 100120 (Rev 12/05)

ADP Approved (ADP use only)DateApprover**For Access to Confidential ADP Drug Medi-Cal Information****Vendor:** _____

To ensure the confidentiality of county/direct provider Drug Medi-Cal data, the Department of Alcohol and Drug Programs (ADP) requests the designated vendor identify a primary and a secondary contact to be responsible for approving requests for access to confidential county/direct provider Drug Medi-Cal patient data. Please provide this information in the spaces below and fax this form to (916) 323-0653. If you have questions about this form, please call (916) 323-2043.

Primary Vendor Approver:

First Name: _____	Last Name: _____
Title: _____	
Phone Number: (____) _____	Fax Number: (____) _____
Email Address: _____	
Primary Approver's Signature: _____	
(Signer acknowledges having read the Confidentiality Statement for all ADP AOD users of the ITWS)	

Secondary Vendor Approver:

First Name: _____	Last Name: _____
Title: _____	
Phone Number: (____) _____	Fax Number: (____) _____
Email Address: _____	
Secondary Approver's Signature: _____	
(Signer acknowledges having read the Confidentiality Statement for all ADP AOD users of the ITWS)	

Vendor for the Following Counties/Direct Providers:

(Please indicate two digit County number, four digit DMC Direct Provider number)

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Vendor Certification:

As _____ for _____, I certify this organization is a vendor for the above counties/direct providers and designate the individuals identified above to have independent authority to approve access requests to specific confidential county/direct provider Drug Medi-Cal patient data. ADP may rely on approvals, denials, and changes made by these individuals in its processing of access requests for the above listed counties'/direct providers' data. As changes occur to the above approving contacts (name, phone, e-mail or county/direct provider), I will complete a new certification and forward it to ADP. Also, I acknowledge reading the Confidentiality Statement for all ADP AOD users of the ITWS.

By: _____ (signed and printed) Date: _____

Title: _____